Table of Contents

Continued on next page

Table of Contents, Continued

Overview

Introduction

Full-time and Part-time salaried employees choose from among several different healthcare programs. State agencies and employees each pay a portion of health insurance coverage costs. Agencies administer healthcare benefits for their employees and collect and pay premiums to cover the cost of healthcare through CIPPS payroll deductions. Employees are enrolled in a premium conversion plan for "pre-tax" deductions of healthcare premiums in which premiums are exempt from federal, state, and OASDI and HI taxes.

Healthcare coverage is provided on a calendar month basis. One-half of the monthly premium for the coverage month is collected on the paydays of the 16th (of the coverage month) and 1st (of the month following the coverage month). Example: Premiums for June coverage are collected on the June 16th and July 1st paydays. Healthcare rate schedules are located in the Payroll Fiscal Year-End Bulletin on the DOA website.

HIPAA

Beginning April 14, 2003, Health Plans, including medical, prescription drug, dental and vision benefits are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. For more information, visit the website of the Department of Human Resources Management (www.dhrm.virginia.gov).

Central Benefits Administration

The Office of Health Benefits in the Department of Human Resource Management (DHRM):

- Administers statewide health benefits and premium conversion plans,
- Manages the Health Insurance Fund (HIF) to which premiums are deposited and from which claims and other bills are paid, and
- Operates the automated Benefits Eligibility System (BES), which serves as the official healthcare enrollment record of the Commonwealth.

Continued on next page

Overview, Continued

Agency Benefits Administration

Agency benefits administrators are responsible for processing new enrollments and enrollment changes, validating employee eligibility, and maintaining BES. When notified of new hires or qualifying status changes, benefits administrators advise payroll administrators immediately to ensure the correct premium rates are applied in payroll processing.

Detailed administrative guidelines governing healthcare plans and BES are available from DHRM.

Central Payroll Administration

State Payroll Operations in the Department of Accounts:

- Runs CIPPS, in which payroll deductions for healthcare plans are processed,
- Runs the interface between BES and CIPPS, which automates the establishment and maintenance of CIPPS healthcare data based on BES updates,
- Runs the automated healthcare reconciliation, which compares BES enrollment records and CIPPS payroll records to identify differences, and
- Reviews monthly certification of healthcare reconciliation forms and IAT's submitted by agencies and reports status in the Comptroller's Quarterly Report on Statewide Financial Management and Compliance.

Agency Payroll and Fiscal Administration

Agency payroll administrators ensure CIPPS payroll deductions are established for employees based on the healthcare plan, and effective dates provided by agency benefits administrators. Both employee and agency portions are computed in CIPPS during payroll processing. The employee portion is deducted from pay, the agency portion is charged to agency expenditures, and the combined total is transferred to the HIF.

Agencies must review the reconciliation reports, verify exceptions and process IAT's (if applicable) to ensure the correct amount of premiums are collected for each employee (both employee and agency portions).

Premium Refund Policy

Retroactive Healthcare Changes

Agencies can make retroactive healthcare changes in BES and applicable premium refunds resulting from administrative error or employee status change up to 59 days following the effective date of the change. After 59 days, agencies must contact DHRM for approval and assistance in updating BES.

Premium refunds should not be processed in CIPPS until BES has been updated.

Tax Consequences of Premium Conversion Refunds

State employees enjoy the tax savings of the premium conversion (pre-tax premium) program authorized by section 125 of the Internal Revenue Code. Under IRS rules, the premium actually constitutes a salary reduction, with the state providing the healthcare benefit. Consequently, when employees participating in premium conversion receive refunds in a calendar year subsequent to the year the premium was originally deducted, a corrected W-2 (Form W2-C) may be required.

Premium Refund Guidelines

When healthcare deductions (premiums) are withheld in error, the CIPPS deduction refund process should be used to refund the employee deduction, as well as the agency expenditures associated with the premium. The refund must be processed along with the employee's regular payment. Process the refund on HTODA, "Employee Deduction Refund/Adjustment." Reference CAPP Topic 50605, *Tax and Deduction Adjustments,* for instructions.

Special Considerations

Special care should be taken when processing premium conversion deduction refunds. You may need to collect any appropriate taxes due directly from the employee when premium conversion deduction refunds are processed for employees who are no longer receiving regular pay. Upon receipt of the delinquent taxes, the employee's masterfile will have to be updated and taxes deposited. Refer to CAPP Topics 50605, *Tax and Deduction Overrides*, and 20319, *Electronic Federal Tax Payments System (EFTPS*), for procedures.

Continued on next page

BES/CIPPS Processing Features

Benefits Eligibility System

BES is the official healthcare enrollment system of the Commonwealth and the "driver" of health insurance transactions created in CIPPS. To emphasize the importance of this point, the employee benefits screen in CIPPS (HMCU1) displays the message, "Enter Health Transactions in BES." This informational message remains on the screen as a reminder and does not clear after the Enter key is depressed.

BES/CIPPS Interface

Based on BES updates, a nightly interface automatically establishes and maintains CIPPS healthcare deduction data on the HMCU1 screen, eliminating to a significant degree duplicate data entry in CIPPS. The interface changes the CIPPS healthcare plan and provider, and establishes the employee and employer payroll deductions on the H0ZDC screen. Agencies still receive BES/Agency Transaction Turnaround Documents for all BES updates. Agencies must validate the proper coverage was set up in CIPPS by the interface.

Timing Considerations

The timing of transactions entered into BES and CIPPS affects the interface:

- An employee must first be hired in CIPPS, using the Menu/Link functions or individual screen access (H0BNE), to be automatically updated through the interface. Refer to CAPP Topic No. 50305, *New Hires/Rehires,* to establish the employee's record in CIPPS.
- If no match on agency and employee number is made between BES and CIPPS, the transaction is rejected and listed on Report U130, BES/CIPPS Transaction Error Listing. These rejected transactions will not recycle and must be manually entered in CIPPS, as described later in this topic.
- The effective date of the BES transaction dictates when the entry will update CIPPS. Those transactions which do not contain a future effective date will show on the morning of the second day after entry in BES.

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BES/CIPPS Processing Features, continued

Valid Transactions

Valid transactions will update CIPPS. These transactions are listed on Report U131, BES/CIPPS Update Listing. This update listing shows old/new values for two CIPPS codes: provider and plan.

Listed Transactions With No Apparent Change

Generally a change in BES to one of these two CIPPS codes will show on the update listing. However, transactions will be listed with no apparent change when an employee transfers between agencies and the employee retains the exact health insurance plan.

Transfers Between Agencies Other Than at the Beginning of the Month

DHRM policy requires that when an employee transfers from their current agency to a new agency after the first day of a month, the entire healthcare premium for that month should be collected by the current agency, with the new agency collecting premiums for the month following the transfer. Systems limitations prevent the BES/CIPPS interface from operating in this manner. Accordingly, agencies should carefully monitor employee transfer transactions in CIPPS using the BES/Agency Turnaround document.

Particular scrutiny should be applied to turnaround documents with an effective date other than the first of the month. The transaction entered into PMIS by the new agency to transfer an employee's PMIS and BES records immediately initiates the process that results in a healthcare deduction being established in CIPPS. This typically results in the CIPPS healthcare deduction being established prematurely.

Transactions That Require Direct Data Entry in CIPPS

BES is the initial point of entry for most health care transactions. However, the following transactions require direct entry in CIPPS:

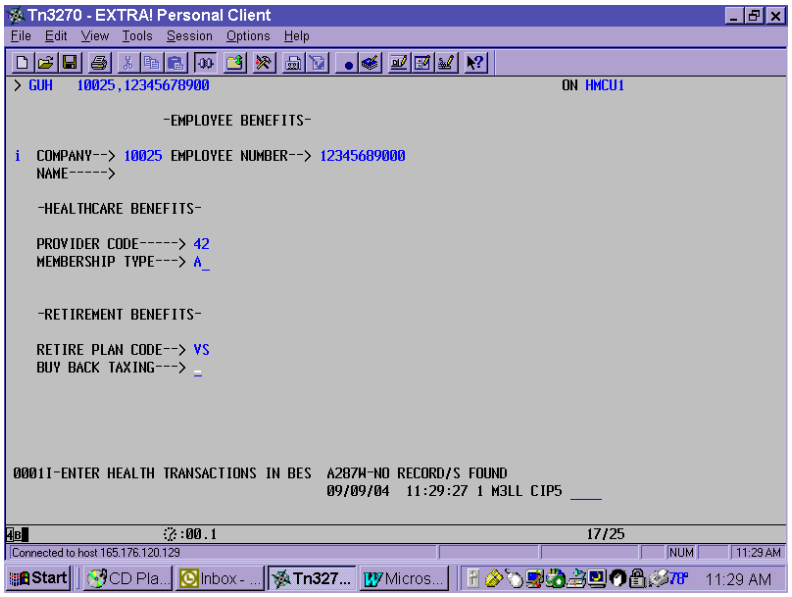
- Transactions rejected during the BES/CIPPS interface process.
- Leave Without Pay (LWOP) – BES does not capture LWOP status
- Termination of Health Insurance Coverage.

Continued on next page

Establishing Healthcare Deductions in CIPPS

Online Data Entry In CIPPS

Transactions rejected during the BES/CIPPS interface, LWOP status changes or termination of coverage must be manually entered. Transaction entry on the Employee Benefits screen (HMCU1) automatically establishes or disables the applicable deductions on the Employee Deductions screen (H0ZDC).



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Establishing Healthcare Deductions in CIPPS, Continued

Enter the provider code for the health benefits plan selected.

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Provider Name	Active Provider Code	Involuntary Separation Provider Code	Project Code
COVA Care Basic	42	92	93002
COVA Care Out-of-Network (OON)	43	93	93002
COVA Care Expanded Dental (ED)	44	94	93002
COVA Care Out-of-Network and Expanded Dental (OON/ED)	45	95	93002
COVA Care Vision, Hearing and Expanded Dental (V/H/ED)	46	96	93002
COVA Care Full	47	97	93002
Kaiser Permanente HMO	06	56	93003

Enter the Active (single letter) and LWOP (double letter) membership type code.

Status	Membership Type
Active	S – Single O – Single – Part time F – Family M – Family – Part time D – Employee plus one dependent T – Employee plus one dependent W – Employee waived coverage
Ineligible/Terminated	E – Employee not eligible for coverage

Leave Without Pay (LWOP)

LWOP Premium Payment

DHRM Policy requires employees on LWOP due to medical leave, agency convenience, or layoffs to continue to pay the employee share. The agency must pay the agency share of the healthcare premium.

For other reasons (e.g., personal, education) the employee must pay the entire healthcare premium.

Coverage Code

Agencies are responsible for entering the appropriate Membership Type on HMCU1 for employees on LWOP. Entering the "Double-Letter" LWOP membership type code causes the entire premium (employee plus employer) to be charged as agency healthcare in CIPPS. The agency is then responsible for collecting the appropriate reimbursement, as determined by the LWOP type (medical or non-medical), directly from the employee.

LWOP Healthcare Rate Schedules

LWOP healthcare rate schedules are located in the Fiscal Year End Payroll Bulletin located on the DOA website (www.doa.state.va.us). The **Agency Payment** refers to the amount initially paid by the agency (i.e., either through payroll deduction or the automated healthcare reconciliation process). **Employee Cost** refers to the amount the LWOP employee will reimburse the agency every month.

Military Leave Without Pay

Military IAT, Healthcare Extended Coverage Premiums

Employees on military leave without pay and/or their covered family members are eligible for the State's contribution to active employee premiums for up to 18 months. Agencies are responsible for paying their portion of the healthcare premium for employees on military leave without pay and enrolled in Extended Coverage.

Anthem will direct bill the employee the amount owed by the employee. When Anthem receives payment from the employee, DHRM is notified. At that time, DHRM will submit an IAT to the agency that covers the agency portion for the listed employee for processing.

All healthcare IAT's go to pre-audit hold for review and release by the DOA Benefits Accounting Unit. It is imperative, therefore, that the agency provides DOA with a copy of the IAT being processed for employees on military LWOP. Additionally, non-healthcare transactions should not be included on the IAT as all transactions will be on pre-audit hold until the IAT is released.

Contact DHRM's Office of Health Benefits for guidance regarding employees on military LWOP

Medicare Carve-Out

Overview

DHRM policy permits employees who are eligible for Medicare because they are diagnosed with end state renal disease (ESRD) to retain healthcare coverage. The State plan pays primary to Medicare for the first 30 months of treatment. After 30 months Medicare becomes the primary payer and the state plan coordinates with Medicare and pays secondary on claims.

Reimbursement Procedure

Employees with ESRD who pay Medicare premiums are eligible for premium reimbursement on a quarterly basis. Agencies should:

- Obtain a copy of employee's Medicare bill or other appropriate documentation.
- Verify Medicare Carveout status in BES.
- Complete Accounting Voucher (per CAPP Topic No. 20310, *Disbursements*) using transaction code 334, object code 1115, expenditure coding determined by agency, batch type 3 or X, with payment made to the employee. This voucher will charge the agency expenditures and generate a check to the employee.
- Process an IAT using the coding in the table below to recover expenditures from the HIF (Health Insurance Fund).
- Submit a copy of the IAT marked **Medicare Carve Out** to DHRM and DOA Health Benefits.

To…	Trans Code	Agency Code	Fund	Rev Source	Project	Object Code
Credit agency	180	Determined by agency.				1115
Charge HIF	340	149	0620	05100	Determined by Provider Code	N/A

Automated Healthcare Reconciliation

Overview

The Automated Healthcare Reconciliation:

- Runs monthly identifying differences between the premium due according to the BES healthcare plan enrollment and the premium collected through the combined employee and agency-paid payroll deductions in CIPPS.
- Generates reports that list each difference identified.
- Charges agencies (automated IAT) for differences in which the amount collected through CIPPS payroll is **less than** the amount due in BES.
- Identifies possible "credit due agency." Agencies must process an IAT to receive credit.

Automated IAT

Automated IAT transactions can be identified in CARS by the coding 'HLTHREC' in the CARS agency list number field and 'AUTOMATED HEALTH RECON' in the invoice description field.

The automated IAT is not charged to each employee's unique programmatic data. Default CARS coding for the automated IAT is provided by the agency and maintained on a separate table by DOA Payroll/Benefits Accounting.

Agency IAT

Agencies must prepare and enter an agency IAT for any differences in which the amount collected through CIPPS payroll is more than the amount due in BES. This IAT must also include any differences incorrectly charged through the automated IAT and/or additional charges discovered by the agency that were omitted from the automated IAT. Additional procedures governing agency healthcare IAT processing are provided later in this CAPP topic.

Reconciliation Reports

The U107, U108, U110, and U111 reports are produced by the automated reconciliation. In each report, BES premium amounts are taken from CIPPS healthcare tables based upon the BES plan-provider code. The following table applies to all reconciliation reports.

If…	Then…
The employee's CIPPS plan code changes within the same provider during the month,	The last plan code is used for comparison purposes.
The employee's CIPPS provider code changes during the month,	Multiple exception reports (one for each provider) are generated.

Automated Healthcare Reconciliation, Continued

U107, Healthcare Exception Report

Identifies CIPPS and/or BES records that have a variance in the agency number, provider code, plan code, or amount fields. A separate report is generated for each agency-provider-group number combination. Summarizes the BES Total, Payroll Total, Credit Due Agency, and Charge to Agency (Automated IAT). U107 report logic follows:

If …	Then…
A difference is detected,	An error code identifies the type of exception: • 1 – Same plan code, collections ≠ bill amount. • 2 – Different plan code, collections = bill amount. • 3 – Different plan code, collections ≠ bill amount. • 4 – On BES, not on CIPPS. • 5 – On CIPPS, not on BES.
A payroll record is identified for which there is not a matching BES record within the same provider code,	The exception will print on the U107 with a group number of 'blank'.

U108, Monthly Healthcare Reconciliation Summary

Summarizes the total healthcare costs in BES, the premiums collected in CIPPS, the Credit Due Agency, and the Charge to Agency (Automated IAT). A separate report is generated for each agency-provider-group number combination. Premiums Due are itemized by plan code.

U110, BES Premium Listing

Lists the eligibility information in BES by provider and group number. This report is a BES bill that supports the BES premiums due amount on the U108 Summary. It may be used to determine an employee's coverage in BES. Do not submit the U110 to DOA with the Healthcare Reconciliation unless it is required to document an exception.

U111, Invalid Healthcare Plan/Provider Codes

Lists all employees with invalid plan or provider codes in BES or CIPPS. Transactions on this report have not been included in the automated reconciliation. Therefore, agencies must review each exception listed and take corrective action.

Reconciliation Procedures

Healthcare Adjustments Worksheet

Use this worksheet to document any adjustments required to change the amounts identified in the automated reconciliation. Examples include retroactive adjustments (which require an additional premium due or a reduction in premiums due) and coverage termination (which require a reduction in premiums due). Obtain copies and/or Excel spreadsheets of the Adjustments Worksheet from the DOA website (www.doa.virginia.gov).

Reviewing Differences on the U107

Review every employee listed on the U107 to determine if the differences identified through the automated reconciliation are correct. Use source documents such as enrollment forms and BES Turnaround Documents in your review. Agencies may also identify additional differences that were not identified by the automated reconciliation.

Listing Differences on Adjustments Worksheet

Generally, each employee with an adjustment, whether resulting in a credit or additional charge to the agency, must be listed on the worksheet as specified below. However, as a general rule, do not list employees who are already identified on the U107 under the column Credit Due Agency.

If…	Then…
the total of the Credit Due Agency column on the U107 is correct,	use the U107 as documentation in place of the worksheet.
employees are listed under the Credit Due Agency column for which agency research indicates the credit is not due,	simply line through the employee amount on the U107, reduce the total under the Credit Due Agency column.
employees are listed under the Charge To Agency column for which agency research indicates a charge should not have been made,	list the employee on the adjustments worksheet, provide an explanation and the BES (PSB305 or PSB309 detail) screen print.
employees are not listed on the U107 for which agency research indicates an additional charge or credit is due,	list the employee on the adjustments worksheet, provide an explanation *and the BES (PSB305 or PSB309 detail) screen print for a credit.*
the BES Total column is incorrect due to changes made after the generation of the healthcare bill,	*list the employee on the adjustments worksheet, provide an explanation and the BES (PSB305 or PSB309 detail) screen print.*

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Reconciliation Procedures, Continued

Compiling and Totaling Adjustments

Bring forward the (adjusted) total Credit Due Agency from the U107 to the adjustment worksheet. Add this total to the other adjustment amounts listed on the Adjustments worksheet, deducting charges and adding credits. If the total is positive, the agency is due a refund from the HIF (agency credit). If the total is negative, the agency owes the HIF (agency charge).

BES Screen Prints

All requests for credit amounts must be supported by a screen print of the PSB305 (Participant Data) for active employees or the PSB309 (Participant History detail) for terminates. The date of the transaction and the transaction type must validate the refund request.

NO REFUNDS (with the exception of those listed on the U107 as "Credit Due Agency") are allowed without the applicable BES screen print.

Agency IAT

Agencies must prepare and enter an agency IAT to request refunds for credits due the agency or to pay additional charges due the HIF. DOA will not make corrections to agency IAT's online. DOA will place IAT's with errors on agency-hold (Status 3) and notify the agency. Agencies must then correct the IAT, release it into CARS, and submit corrected supporting documentation (including a new batch header) to DOA.

The following table summarizes CARS transaction coding for processing agency healthcare IAT's. Omit Program, Sub-program, and element for transfer lines affecting the HIF (Agency 149).

Used when…	To…	Trans Code	Agency Code	Fund	Rev Source	Project	Object Code
Payroll deductions exceed BES.	Credit agency	180	Determined by agency.				1115
	Charge HIF	340	149	0620	05100	Determined by Provider Code	N/A
Payroll deductions are less than BES.	Charge Agency	380	Determined by agency.				1115
	Credit HIF	136	149	0620	05100	Determined by Provider Code	N/A

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Reconciliation Procedures, Continued

Certification Form Submission Requirements

Once all plans are reviewed, the approving Officer certifies the accuracy by signing the Certification form and submitting it to DOA along with all required supporting documentation. Obtain copies of the Certification Form from the DOA website (www.doa.virginia.gov).

Healthcare reconciliation/certifications are due by the end of the month following the coverage month. However, the May reconciliation is due mid-June. The exact due date is documented in the FYE Payroll Bulletin

Continued on next page

Reconciliation Compliance Reporting

Sunset Policy

Agencies forfeit claims to agency healthcare expenditure refunds when healthcare reconciliation/certifications are either not submitted or contain problems that remain unresolved more than two months following the close of the coverage month (one month following the reconciliation/certification due date). Under this policy, late refund IAT's will be deleted and any required charge IAT's will be processed centrally. Employee premium refunds are not affected.

Compliance Reporting

Agencies whose healthcare reconciliation/certifications are submitted late or with problems requiring additional adjustments are subject to being reported in the Comptroller's quarterly *Report on Statewide Financial Management and Compliance.*

Internal Control

Internal Control

Agencies must ensure all employee and agency premiums due according to BES are paid.

Records Retention

Time Period

All applicable forms affecting employee healthcare plan eligibility and the related payroll deductions must be maintained at the agency for four years or until audited, whichever is later.

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Contacts

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Subject Cross References

References

CAPP Topic No. 20319, *Electronic Federal Tax Payments System*
CAPP Topic No. 20310, *Disbursements*
CAPP Topic No. 50305, *New Hires, Rehires, Transfers*
CAPP Topic No. 50605, *Tax and Deduction Adjustments*